Ombudsman Saskatchewan Annual Report 2015

Ombudsman Saskatchewan

Promoting Fairness

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Ombudsman Saskatchewan
Promoting Fairness

April 2016

Speaker of the Legislative Assembly
Province of Saskatchewan
Room 129 Legislative Building
2405 Legislative Drive
Regina, Saskatchewan S4S 0B3

Dear Mr. Speaker:

In accordance with subsection 38(1) of *The Ombudsman Act, 2012*, it is my duty and privilege to submit to you the forty-third annual report of Ombudsman Saskatchewan for the year 2015.

Respectfully submitted,

Mary McFadyen
OMBUDSMAN

Vision, Mission, Values and Goals

Ombudsman Saskatchewan also serves as the Office of the Public Interest Disclosure Commissioner. Our vision, mission, values and goals reflect our dual role:

Vision

Our vision is that government is always accountable, acts with integrity, and treats people fairly.

Mission

Our mission is to promote and protect fairness and integrity in the design and delivery of government services.

Values

We will demonstrate in our work and workplace:

- fairness, integrity and accountability
- independence and impartiality
- confidentiality
- respect
- competence and consistency

Goals

Our goals are to:

- Provide effective, timely and appropriate service.
- Assess and respond to issues from a system-wide perspective.
- Undertake work that is important to the people of Saskatchewan.
- Demonstrate value to the people of Saskatchewan by making recommendations that are evidence-based, relevant and achievable.
- Be experts on fairness and integrity.
- Educate the public and public servants about fairness and integrity.
- Have a safe, healthy, respectful and supportive work environment.

Ombudsman's Message

2015 was a busy and productive year for Ombudsman Saskatchewan. We saw some very significant changes to the Ombudsman's mandate, responded to increased complaints, and conducted a number of investigations, one of which resulted in a public report. We also reached out to meet directly with complainants in several communities across Saskatchewan.

Mary McFadyen, Saskatchewan Ombudsman

OUR ROLE

As an Officer of the Legislative Assembly, the Ombudsman's role is to assist the Legislative Assembly in ensuring that provincial government ministries, Crown corporations, publicly-funded health entities, and most other provincial agencies, boards and commissions deliver services to citizens fairly. Since 1973, we have carried out this role by receiving, resolving, and investigating citizens' complaints about provincial government organizations.

OMBUDSMAN'S JURISDICTION EXPANDED

On November 19, 2015, the Legislative Assembly expanded the Ombudsman's mandate to include jurisdiction over Saskatchewan's 780 cities, towns, villages, resort villages, rural and northern municipalities, and their council committees, controlled corporations and other bodies established by their councils, plus approximately 3,700 municipal council members. Although municipalities have wide discretion over how they exercise their statutory powers and have been long recognized as a separate level of government, it is prudent for the Legislative Assembly to give citizens a way to help ensure these powers are exercised fairly, reasonably and in the public interest.

22% INCREASE IN COMPLAINTS IN 2015

In 2015, we saw a substantial increase in complaints. We received 3,618 complaints. Of those, 2,813 were within our jurisdiction and 805 were outside our jurisdiction. This is a 22% increase in jurisdictional complaints over 2014. This does not account for the further increase in complaints we expect from our new jurisdiction over municipalities.

PERSUASION AND CO-OPERATION FIRST

The Ombudsman Act, 2012 gives the Ombudsman the mandate to investigate complaints. However, before beginning a formal investigation, we always try to resolve issues informally, if possible and appropriate. In this report, we highlight some of the complaints we successfully resolved, both formally and informally.

INVESTIGATIONS AND RESULTING RECOMMENDATIONS

On May 13, 2015, we reported on an important investigation into long-term care in Saskatchewan that we initiated at the request of the Minister of Health. Over six months, we investigated the care being provided at the Santa Maria Senior Citizens Home in Regina. We made 19 recommendations aimed at improving the quality of care at Santa Maria, and the oversight and leadership provided by the Regina Qu'Appelle Health Region and the Ministry of Health to long-term care facilities throughout the region and the province. We also asked for and received updates from Santa Maria, the Region and the Ministry on their progress in implementing our recommendations. We have reported their progress in this *2015 Annual Report*.

We also completed many other investigations in 2015, making 65 recommendations to 11 entities. Of those, only one recommendation was not accepted and one was partially accepted. Summaries of several investigations and the subsequent recommendations are included in this annual report.

SERVING SASKATCHEWAN

We continued to look for opportunities to reach out to residents outside of Regina and Saskatoon, and to fulfil our public education mandate. In 2015, we offered public information sessions and set up temporary offices for a day to meet directly with residents in Meadow Lake, Lloydminster, Kindersley and Yorkton.

This past year, we also provided 19 "Fine Art of Fairness" workshops to various provincial government ministries and organizations. This training is aimed at helping public servants understand the role of the Ombudsman, what administrative fairness is, and how to better communicate with the public when acting on behalf of the government. In the past, this training was offered as a two-day workshop. However, in my meetings with various officials, many said that, while they feel this training is valuable, two days was a significant time commitment for their staff. As a result, we shortened our training to a one-day session, which has been well received.

CLARIFICATION THAT OMBUDSMAN SASKATCHEWAN IS NOT PART OF EXECUTIVE GOVERNMENT

On May 14, 2015, the Legislative Assembly passed *The Officers of the Legislative Assembly Standardization Amendment Act, 2015*, which clarifies that employees of the Officers of the Legislative Assembly, including the Ombudsman and Public Interest Disclosure Commissioner, are not part of the Executive Government. This is an important clarification since our role is to assist the Legislative Assembly in ensuring that the Executive Government carries out its mandate fairly. It is important that citizens feel that their complaints and concerns are being reviewed by an independent and impartial body that is not part of the government organizations they are complaining about.

FUTURE DIRECTION

Our priority for 2016 is to integrate the influx of complaints we expect to receive about municipal entities into our current procedures for receiving, investigating and resolving complaints.

From November 19, 2015 to the end of the year, and without any real public awareness of our new role, we received 33 complaints about municipalities. Of those, 13 included issues about the conduct of municipal council members. From our discussions with other ombudsman offices across Canada, we are aware that investigations into council member conduct can be quite resource intensive. We want to ensure that our ability to carry out the other aspects of our mandates – such as addressing complaints about the provincial government and carrying out responsibilities under *The Public Interest Disclosure Act* – are not diminished.

We have already met with various municipal groups to explain the Ombudsman's role, including the Saskatchewan Urban Municipalities Association, the Saskatchewan Association of Rural Municipalities, and the Saskatchewan City Mayors' Caucus. We will continue to meet with municipal leaders and officials, and we look forward to having good working relationships with municipalities, just as we do with provincial government organizations. There is a strong desire in the municipal sector for information about administrative fairness and the role of the Ombudsman. We have already begun taking steps to increase awareness of the Ombudsman's role in this sector.

We are proud of the work we do and are proud to outline some of those accomplishments in this *2015 Annual Report*. We also look forward to meeting the challenges that will come with our newly-expanded role of oversight over the municipal sector.

Complaints

When individuals believe a government entity – such as a provincial government ministry, agency or health entity, or a municipal entity – has been unfair to them, they are often able to raise the issue themselves and work out a resolution with the office involved. There are times, however, when resolutions do not come about so easily. For example, policies may be applied too rigidly, explanations may be unclear, or people on both sides may become hardened in their respective positions.

By the time people contact us, they are often frustrated. In addition to seeking a solution, they also want to be heard. Listening is our first step. Next, we determine whether the government entity is within our jurisdiction, whether the issue fits within our mandate and, if so, which of our services will be the most useful.

We may provide coaching or referral information; we may help parties resolve matters quickly and informally; we may facilitate communication between parties who are no longer talking to each other or who are having trouble communicating effectively; or we may conduct a formal investigation. At the conclusion of an investigation, we may make recommendations to the government entity.

On the following pages are several case examples that demonstrate the kinds of complaints people brought to us in the past year and the ways we resolved them.

Names have been changed to protect the confidentiality of those involved.

Early Resolution

CANCELLING THE CANCELLATION FEE

Saskatchewan Government Insurance (SGI)

An SGI broker told Jim that an Auto Pak would cost $200 – $210. Jim agreed to purchase it, so the broker submitted the paperwork. A few days later, Jim received a $500 invoice. Jim called the broker to complain and was told that he could cancel the Auto Pak, so he did. SGI then charged him a $55 cancellation fee. He did not think this was fair and contacted our Office.

We checked with the SGI Fair Practices Office and they explained that, while $200 is a fairly typical cost, the cost will vary based on the person's driving history. The Fair Practices Office did not know how well the broker explained this to Jim, so they withdrew the cancellation fee.

Status: Resolved

CORRECTING AN OLD MISTAKE

SaskPower

Jane and Ivan lived in rural Saskatchewan. They received a credit of over $2,000 on their SaskPower bill, so Jane contacted SaskPower to find out why and to ask for a payout. The person she talked to thought the credit was unusual, so asked Jane to take a photo of the meter and send it in. She did. The reading was much higher than what SaskPower had on file, so a local employee came out to read the meter. He confirmed the higher number. He also showed them a high meter reading he had taken at their place the year before. With the employee's help, Jane and Ivan checked their appliances to see which one could be drawing so much power. They concluded that it may have been a boiler.

Upon receiving confirmation of the higher meter reading, SaskPower sent Jane and Ivan a new bill. It showed a carryover amount of over $10,000 and a total close to $12,000.

Jane and Ivan reviewed their past bills. They noticed that the "actual meter reading" for the bill from the year before was much lower than the reading the local employee had recorded. They thought this was an error and that the estimated meter readings that followed were based on that error. They believed that, if billing had been correct, they would have been alerted to the increased consumption sooner and would have taken steps to find and correct the problem.

Jane contacted SaskPower several times. Although she was eventually offered a 20% reduction in the amount owing, plus extra time to pay, she did not think this was fair and contacted our Office. Shortly after she contacted us, she received notice that if she did not pay, her power would be cut off.

Jane provided us a copy of her bills and the information she had collected. We contacted SaskPower to provide Jane's information and inquire about the situation. SaskPower agreed not to disconnect her power while her information was being considered. When a manager reviewed the details, she realized that an error had been made. She contacted Jane, apologized on behalf of SaskPower, and offered to forgive about $10,000 of the outstanding bill. As a result, Jane and Ivan only owed a fraction of the original sum and they were given additional time to pay it off to minimize any financial pressure.

Status: Resolved

THE DIFFERENCE BETWEEN HEARING AND LISTENING
Regina Qu'Appelle Health Region – Pioneer Village

Jan's mother was a resident of Pioneer Village. She had a condition that required significant attention from staff and from Jan. Jan noticed changes in her mother's sleeping and eating patterns, so she talked to several staff members and a manager about her concerns. She noted that, because of the changes in her mother's sleep patterns, her father had been unable to visit and that this was hard on both of them. She also said that personal items had gone missing, and that her mother had been walking around in bare feet because of soiled shoes. Jan said she wanted to have a meeting to discuss her mother's care, but this did not happen.

Jan contacted our Office. She told us she was frustrated with the lack of action on her mother's care. We contacted an official from the Regina Qu'Appelle Health Region, who promptly met with Jan. Jan called us back to tell us that the meeting went very well and that she felt that her concerns had been understood. The official also arranged a meeting with the facility so they could listen to Jan's concerns and discuss how to address her mother's care.

Status: Resolved

Facilitated Communication

IF IT'S NOT ON FILE...
Ministry of Social Services – Regina Housing Authority (RHA)

Ida was an older adult who learned that, due to a change in building management, she would now be renting from the RHA. She attended a tenant information session. At the end of the session, an RHA employee told Ida that she owed the RHA about $800. Ida could not recall the debt, but agreed to a meeting.

At the meeting, Ida was told that more than 10 years earlier, when she had been renting from the RHA, a pre-authorized rental payment had not gone through due to insufficient funds. A few months after that, Ida had moved and the RHA did not know how to contact her – until now. The employee offered to reduce the bill to $600, but told Ida that if she didn't sign a new lease and commit to a repayment plan, she would be served an eviction notice.

Ida did not remember missing any rent payments. She and her son went to the bank to look up her old account records, but learned that she would have to pay a fee to access information that was more than seven years old.

Ida contacted our Office. She told us she was worried about being evicted. She said she had lived at the previous apartment for five months after the alleged missed payment, and did not understand why they had never talked to her about it. She said she was not trying to cheat anyone, but wanted proof that she owed the money.

We contacted the RHA about Ida's situation. A manager met with her to explain that all tenants had to sign a new lease and to assure her that she did not need to worry about being evicted. The manager agreed to produce evidence of the debt from the RHA's archives. The manager later confirmed that no documentation had been found, so the debt would be cancelled.

Status: Resolved

DOCK OPTIONS
Ministry of Parks, Culture and Sport

Irene had a lakefront cottage in a Saskatchewan provincial park. With an increase in water levels, some cottage owners in her area were interested in putting in docks. The park staked out several locations for docks. In most cases, if there was a staked location in front of a lakefront property, that cottager would have the first option to build a dock there.

Irene didn't want a dock, but Jasper did. His cottage was not on the lakefront, so he asked Irene if he could build a dock at the location staked out in front of her property. Based on some information the cottagers had previously received about shorelines, Irene did not think she had a choice. She said she did not want the permit in her name, so Jasper requested the permit in his name and built a dock.

In the meantime, Irene was thinking about selling her cottage in a few years and thought that a dock would be attractive to buyers. She contacted the park to see if she could get the permit for that space, but was told that she could not because she had given it up. She asked about a permit for another location, but was told they were all taken.

Irene did not think the process was fair and contacted our Office. She told us that she wasn't given clear information at the beginning, when the stakes first went up.

We talked with Irene, her neighbours, and staff at the park and the Ministry to learn more about what had happened and to see if there were any options that could be worked out. Staff checked the shoreline and identified a new location that would be suitable for a dock. They offered it to Jasper and he accepted it. Irene could now apply for the dock permit on the space in front of her cottage.

Status: Resolved

Investigations

CHECKING ASSUMPTIONS
Ministry of Social Services
Saskatchewan Social Services Appeal Board (SSAB)

Iris learned that she qualified for Saskatchewan Assured Income for Disability (SAID) benefits and Supplementary Health Benefits (SHB). She had a problem tooth and was placed on an emergency wait list for oral surgery.

Due to her circumstances, her SAID benefits only lasted a month. She received notice that she no longer qualified for SAID or SHB. She had the surgery about a month later and paid about $400.

Since the surgery had been arranged while she was receiving benefits, Iris believed that it would be covered, but was told that it was not. She appealed to the Social Services' regional appeal committee and then to the SSAB. Both appeal bodies believed that they had no authority to make decisions in the area of health benefits. She did not think this was right and contacted our Office.

We provided a notice of investigation to Social Services and the SSAB. Shortly afterwards, we received a letter from Social Services. It acknowledged that mistakes had been made and outlined how they would be corrected.

- Before Iris's SAID benefits ended, she told Social Services staff about her surgery plans. They should have offered to do an assessment to determine her ongoing health services needs and determine whether she would be eligible to continue receiving SHB.
- Social Services said it would contact Iris, apologize to her, reimburse her for the surgery cost, and offer to do a health assessment to determine her eligibility for SHB.
- Social Services said it would remind and train staff to offer SHB health assessments to clients whose SAID benefits are ending.
- Since Social Services staff have the ability to determine eligibility for SHB, their regional appeal committees and the SSAB have the authority to review these decisions. Social Services contacted both appeal bodies to inform them of this.

Status: Resolved

A MATTER OF DIGNITY
Ministry of Justice – Corrections and Policing

Joe contacted us while at a provincial correctional centre. He told us that he broke sprinkler heads in his cell while suffering a panic attack. He said he was then strapped into a restraint chair while naked and then placed in a room where nurses and other staff could see him. We investigated and made several findings.

After Joe broke the sprinkler in his cell, he took off his wet clothes. Staff placed him in a dry institutional smock and moved him to another cell. He then undressed, interfered with the camera in the cell, and broke another sprinkler head. He was removed from the cell and, while naked, placed in a restraint chair.

According to Corrections policy, an inmate can be placed in a restraint chair to prevent the destruction of institutional property. Based on the video evidence, we found that staff did not use more force than necessary while placing him in the restraint chair.

Once in the chair, a towel, along with another towel or smock, were placed across his lap to cover him. He was taken to the exercise room. The coverings eventually fell or were kicked off. He told staff that he was cold, uncomfortable and embarrassed. He said he accepted the consequences of being in the chair and that he was sorry. Although his vital signs were checked from time to time, he was not covered up again. For the last 45-50 minutes that he was in the chair, he was naked. We found that he had not been treated with dignity.

Joe spent about an hour and a half in the chair. In our view, he might have been removed sooner since he seemed to have calmed down while in the chair and expressed remorse. The time frame was, however, within the limits set by policy.

While reviewing the video evidence, we found one record that was not time and date stamped. There was also no video record of Joe's removal from the chair. We were told that the camera in that room had malfunctioned.

Based on these findings, we recommended that the Ministry of Justice – Corrections and Policing:

1. Write Joe to apologize for failing to ensure he was clothed while in the restraint chair, and provide us a copy of the letter.

   Status: Accepted

2. Ensure that videos of restraint incidents depict the entire event, as required under policy, and that such video be date and time stamped, and that steps are taken to ensure that there are no gaps or blind spots in the videos.

   Status: Accepted

3. Ensure all video is kept in a permanent file along with the written reports of the incident and securely retained in accordance with an appropriate operational records management system.

   Status: Accepted

THE INVISIBLE PROGRAM
Saskatoon Health Region

Two families contacted us about the Saskatoon Health Region's Individualized Funding (IF) program. The program is an option available in the Region's Home Care program. Eligible individuals who are accepted into the IF program are given funds to arrange and pay for supportive care services on their own.

Josie & Iona
Josie's mother Iona was receiving home care from the Region. Josie thought her mother needed more services than home care could offer, so told Region staff that she was looking for alternative care. Thinking there were no other options, she hired a live-in caregiver. A few years later, Josie learned about IF from Service Canada, so she requested it from the Region. Iona was placed on a wait list. Region staff estimated that the wait would be about 19 months. After about two years, Josie contacted our Office. She told us that she had trouble getting clear information about where Iona was on the wait list. After our initial inquiries, Iona was reassessed and offered IF program funding.

Jessica & Issac
Jessica's husband, Isaac, needed constant care. When an acquaintance told Jessica about IF, she contacted the Region. Isaac was assessed and placed on the wait list. Staff told Jessica that due to lack of funding, no new clients were being accepted into the program. She told us that when she called the Region periodically over the next few months, she did not get clear information about when IF would accept new clients. She hired a lawyer who advocated for Issac's acceptance into the program. The Region granted funding a couple of months later.

Although both families were eventually offered spots in the IF program, they encountered similar problems: they did not hear about the program from the Region; and they did not understand how the wait list was being managed or how long they would be on it. One family also questioned whether Ministry of Health rules permitted the use of a wait list.

We investigated and found that the Ministry of Health's *Home Care Policy Manual* requires regions to offer an IF program, but does not require it to be provided immediately to all who qualify. We concluded that wait lists can be used as long as the criteria are understandable and periodic updates are provided.

The Saskatoon Health Region provided an IF program, but only funded a small number spots. A Region official told us that the Region did not promote the program because there is little point in telling people about it if there is no hope of them ever receiving funding. In our view, it was not fair to withhold information about the program from families. If the wait list increased as a result of the program being properly promoted, then the Region and the Ministry would have useful information for making funding decisions, and families would have the information they need to make decisions about how to care for their loved ones.

The Region staff we interviewed did not have a common understanding of how the wait list is managed or how service requests are prioritized. Neither Jessica nor Josie knew who to call and both told us that they received different information from Home Care and the Region's Client/Patient Access Services (which conducts the eligibility assessments for IF).

Based on our findings, we made the following recommendations to the Saskatoon Health Region:

1. Take reasonable steps to inform the public and Home Care clients about the program.

   Status: Accepted

2. Have consistent and transparent wait list assessment criteria.

   Status: Accepted

3. Provide applicants with accurate and timely wait list information.

   Status: Accepted

IMPROVING COMPLAINT HANDLING
Extendicare (Canada) Inc. – Extendicare Sunset

Families of residents at Extendicare Sunset were concerned about the quality of care in the facility. They raised issues with local administrators, leadership at Extendicare (Canada) Inc. (ECI), and the Regina Qu'Appelle Health Region (RQHR). Several meetings took place and while there was some progress, families believed they were still seeing too many incidents of poor quality care. Families and staff began to contact us.

In the meantime, ECI had arranged for a regional director to meet with Sunset staff to hear their concerns and introduced various quality-of-care control checks.

With staff and management working on the quality of care, our investigation focused on Sunset's concern-handling efforts. How had staff and management responded to the various concerns families and staff raised?

While ECI has a complaint-handling policy, we found that staff and management at Sunset were not well aware of it, how to apply it, or how to communicate with families about how their complaints would be handled. The policy itself did not meet Ministry of Health or RQHR requirements. For example, it did not reference RQHR Patient Advocates (who can help residents and families who have concerns), it did not say how residents and families should be informed about complaint-handling processes, and it did not refer to Sunset's obligations under *The Ombudsman Act, 2012* to notify residents of the Ombudsman's services and to provide residents a confidential means of communicating with our Office.

Based on these findings, we recommended:

1. That Extendicare (Canada) Inc. update its complaint handling policy to include all provincial and health region requirements, and ensure that all staff in its Saskatchewan facilities are educated on the policy and its procedures.

   Status: Accepted

TRANSITIONING YOUTH WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES BETWEEN THE CHILD AND FAMILY SERVICES PROGRAM AND THE COMMUNITY LIVING SERVICE DELIVERY PROGRAM

Ministry of Social Services

Turning 18 is a major life event for any young person in Saskatchewan and most young people transition gradually from childhood to adolescence to full adulthood while living in supportive families. Supportive families provide children and youth the time, opportunity, and emotional and financial support to build the necessary life skills to become independent. For youth in care of the Ministry of Social Services, turning 18 not only means their time in care ends, but for many, it also means the end of financial, educational, vocational, mental health and other services provided or funded by the child welfare system. Youth "aging out" of care are expected to have the skills to navigate the adult world independently upon leaving foster care. Good transitional planning is critical to a youth's successful transition from care to independence. Transitioning a young person with intellectual disabilities can be more complex and challenging, not only for the young person and his or her family, but also for Social Services. When a youth in care with intellectual and developmental disabilities ages out of care but requires ongoing support and services from the adult system, Social Services' Child and Family Services (CFS) program staff can refer the youth to Social Services' Community Living Service Delivery (CLSD) program. If the young person is eligible and if services are available, the CLSD program can assume service responsibility and the youth is then transitioned between the two programs – theoretically without a break or disruption of services.

Between 2008 and 2012, Ombudsman Saskatchewan received several complaints about the services provided by Social Services during or following the transition of youth between the CFS and CLSD programs. On August 30, 2012, we provided notice of our intention to investigate the process Social Services used to transition youth (from 16 to 21 years of age) from the CFS program to the CLSD program. The review formally began in December 2012 and was completed in the summer of 2014.

Our Findings

In 1999, to facilitate transition planning between the two programs, Social Services created a shared policy known as the *Protocol for Adult Transition Planning of Individuals in Care of the Minister* (the Joint Protocol). The Joint Protocol, along with related CFS and CLSD program policies, established practice guidelines for Social Services staff to follow when transitioning a youth from the CFS program to

the CLSD program. The intention was to use one common planning framework to facilitate a young person's transition from care to the community.

We identified several issues with the Joint Protocol and the process Social Services used to transition youth:

- The Joint Protocol was not based on best practices.
- Social Services staff, caregivers, and other stakeholders involved or who should be involved in transitioning youth from the CFS program to the CLSD program were generally unfamiliar with the Joint Protocol.
- Social Services staff from each program did not effectively collaborate with each other, or with the youth and other key stakeholders during the transition process.
- Communication among the staff of the CFS and CLSD programs during the transition process was generally poor and inconsistent.
- There were few avenues for those affected by Social Services' decisions to have the decisions reviewed; there was no dispute resolution process to help resolve disagreements when they arose during the planning process.

Social Services staff, caregivers, and community-based organizations expressed their concerns about Social Services' ability to accurately identify the youth in its care under the CFS program who require and are eligible for CLSD services. Similar concerns were raised about the capacity of the CLSD program, and more generally the adult system, to absorb these youth once they age out of care.

Social Services staff and other stakeholders also told us about what they perceived to be funding inequities between the CFS and CLSD programs that negatively affected the transition of youth in care to the CLSD program. Although we did not find that there was a significant funding disparity, the perception among staff and stakeholders should still be addressed as it clearly affected interactions between caregivers and Social Services staff.

Recommendations

We made 26 recommendations to Social Services aimed at improving the transition of youth in care with intellectual and developmental disabilities between the CFS and the CLSD programs. Tentative recommendations were provided to Social Services in August 2014. In March 2015, Social Services accepted all our recommendations, advised us that it has developed and

implemented a comprehensive policy and transition process to replace the Joint Protocol, and that it also continues to update its policies and programs related to transitioning youth from CFS to the CLSD program.

For a complete list of the 26 recommendations and the status of Social Services' progress in implementing them, please see www.ombudsman.sk.ca.

COMPARING DEADLINES
Ministry of Social Services

When a social assistance recipient rents a place to live, Social Services provides the landlord with a letter of guarantee instead of a security deposit. When the tenant moves out, the landlord can submit a claim against the letter of guarantee to Social Services for cleaning, damages or unpaid rent. If the claim is paid, Social Services then collects the amount from the tenant. It is treated as an overpayment and a portion of the total is taken off the person's social assistance benefits until the amount has been repaid.

Jane, a social assistance recipient, received a notice from Social Services that her landlord had submitted a claim. She disagreed with the claim and noticed that Social Services gave her only 14 days to dispute it, even though legally she had 120 days to dispute the claim with the Office of Residential Tenancies (ORT). She disputed the claim with the ORT and Social Services, and contacted our Office to complain about the 14-day deadline. The ORT found in her favour and Social Services repaid the money that had been collected from her.

Even though Jane's problem had been resolved, we thought she raised a good issue – one that potentially affects every tenant on social assistance who enters a rental agreement. We decided to conduct an investigation into this practice.

Under *The Residential Tenancies Act, 2006*, landlords who have taken a security deposit cannot spend the security deposit for 30 days after giving the tenant notice that they are making a claim against it. Given this, we found that giving social assistance recipients just 14 days to dispute a claim for the security deposit guarantee before paying it out to the landlord and charging it as an overpayment was unfairly short.

We also found that the letter that Social Services sends to social assistance recipients references the 120-day dispute deadline provided for in *The Residential Tenancies Act, 2006* and its own 14-day deadline in a way that could be confusing.

We recommended that Social Services:

1. Increase the period a client has to dispute a claim before Social Services pays a landlord under a Guarantee for Security Deposit from 14 days to 30 days.

   Status: Accepted

2. Ensure the notice letters it sends clients pursuant to clause 33(2)(c) of *The Residential Tenancies Act, 2006* clearly state: (a) the time they have to dispute a claim before Social Services will pay a landlord under a Guarantee for Security Deposit and assess an overpayment; (b) to whom the claim must be made; (c) how the overpayment will be collected; and (d) the steps the client must take to dispute the landlord's claim through the Office of Residential Tenancies.

   Status: Accepted

GRADING QUESTIONS
Saskatchewan Polytechnic

Julia was taking a program at Saskatchewan Polytechnic. She passed the academic portion of the program, but on her last day, she learned that she had failed the practical portion of one of her required classes. As a result, she would be discontinued from the program. She also learned that she was being accused of cheating on the final exam.

Julia asked to see how her grade was reached, but was not provided any additional information. She filed a student appeal, but was told that she should apply for a grade appeal instead. She did so, but the appeal was denied. Julia believed that she was being treated unfairly and contacted our Office.

We conducted an investigation that considered:

1. Was the evaluation and grading of the practicum reasonable and was it applied fairly to Julia?
2. Was the appeal process fair and reasonable?

We learned that Julia's practicum grade was based on verbal reports from several field instructors. After Julia requested the evaluation information, the course instructor requested the verbal reports in writing. Gathering written comments after grading had been completed does not appear to be a fair process. Also, while these comments would have been useful to Julia for her appeal, they were never provided to her. We understand that written comments are now required in advance of grading.

We found that the guidance provided to instructors about grading the practicum was not specific enough to ensure consistency. The instructors, in this case, appeared to be interpreting the grading guidelines quite differently. This potentially could result in different grades for the same student based on the same criteria.

Julia was also penalized because the instructor thought she had cheated on the final exam. The Polytechnic's procedures for dealing with alleged academic misconduct were not followed and the allegation not proven. When Julia's exam was finally reviewed, staff found no evidence of cheating. It was therefore unfair for the instructor to rely on an unproven allegation of cheating when grading Julia.

We also found that, although Julia was required to make a grade appeal, her situation was a better fit for a student appeal. Student appeals should be used for potentially unfair academic rulings that have more serious consequences on the student's academic career, such as Julia's being required to discontinue the program.

Based on our findings, Saskatchewan Polytechnic provided Julia with the opportunity to retake the class and complete the program. We made the following recommendations. These were all accepted, except that Saskatchewan Polytechnic did not waive tuition for Julia to retake the class.

1. The Polytechnic should ensure that all instructors for this program grade the practical/professional criteria consistently.

   Status: Accepted

2. The Polytechnic should ensure that the criteria for requesting a student appeal and grade appeal are clear and well understood by students, faculty and administrative staff.

   Status: Accepted

3. The Polytechnic should ensure that the instructors and other evaluators for Julia's class grade her fairly and waive her tuition.*

   * We have reworded this recommendation to help protect Julia's identity.

   Status: Partially Accepted

JUSTICE DELAYED
Office of Residential Tenancies (ORT)

Irwin's apartment needed repairs, but when he told his landlord about it, nothing was done. As a result, some of his possessions were damaged. He eventually made a claim against his landlord to the ORT. He asked the ORT to direct his landlord to make the repairs and award him money for damages.

The landlord did not attend the scheduled ORT hearing. Before the ORT hearing officer rendered a decision, the landlord called, provided a reason for not attending the hearing, and asked for an opportunity to present his case. The ORT decided to re-open the hearing so the landlord would have a reasonable opportunity to respond to Irwin's claim. This delayed Irwin getting a decision. After the ORT heard from the landlord and Irwin, a long time passed without the hearing officer rendering a decision. When Irwin called the ORT to see if a decision had been made, he mentioned some additional issues. The ORT told him a new hearing would have to take place. Since he was still having problems with his apartment, he told the ORT that he would rather get a decision about his original claim than start over with a new hearing that included his new issues. The ORT decided to hold a new hearing. In the end, it was over 10 months from the time Irwin first requested a hearing until he received a decision. Irwin thought it was unfair that the process took so long, so he contacted our Office.

After investigating, we found that since the ORT needed to balance the landlord's rights with Irwin's right to a timely hearing, the delay caused by giving the landlord time to prepare and respond to Irwin's claim was not favouritism.

When Irwin later called to inquire about getting a decision, we found that, since he made it clear that he was more interested in getting results from the first hearing, and given the delay that had already taken place, the ORT should have given him the choice of pursuing his additional concerns or sticking with his original claim.

The ORT was very busy during this period and was candid with us about its challenges and workload. However, the delay Irwin experienced was unreasonable.

We recommended that:

1. The Office of Residential Tenancies establish and implement timelines upon which hearings must be held and decisions rendered, including provisions requiring parties to be informed when any deadline cannot be met, why it cannot be met, and when the parties can expect a hearing to be set or a decision to be rendered, as the case may be.

   Status: Accepted

FOR SALE BY OWNER
Ministry of Social Services,
Saskatchewan Housing Corporation (SHC)

Jerry was a tenant of the SHC and was living in a community eligible for the Rental Purchase Option (RPO) – a program designed to help tenants become homeowners. Jerry had applied to the program three times over the course of six years. Each time, the SHC had provided him with an offer, which he did not accept. A feature of the program resulted in each successive offer being for less money than the last. Several long-time tenants had been able to purchase their homes for a nominal amount. Jerry was waiting until he got a similar offer.

On August 31, 2011, he applied again. When he followed up in April 2012 about the status of his application, he was told that the program had ended on March 31, 2012. He did not think this was fair and tried to resolve the matter but was unable to do so. He then contacted our Office.

We conducted an investigation – not to determine whether the program should have ended, but whether Jerry and others in his situation had been given reasonable notice that the program was ending.

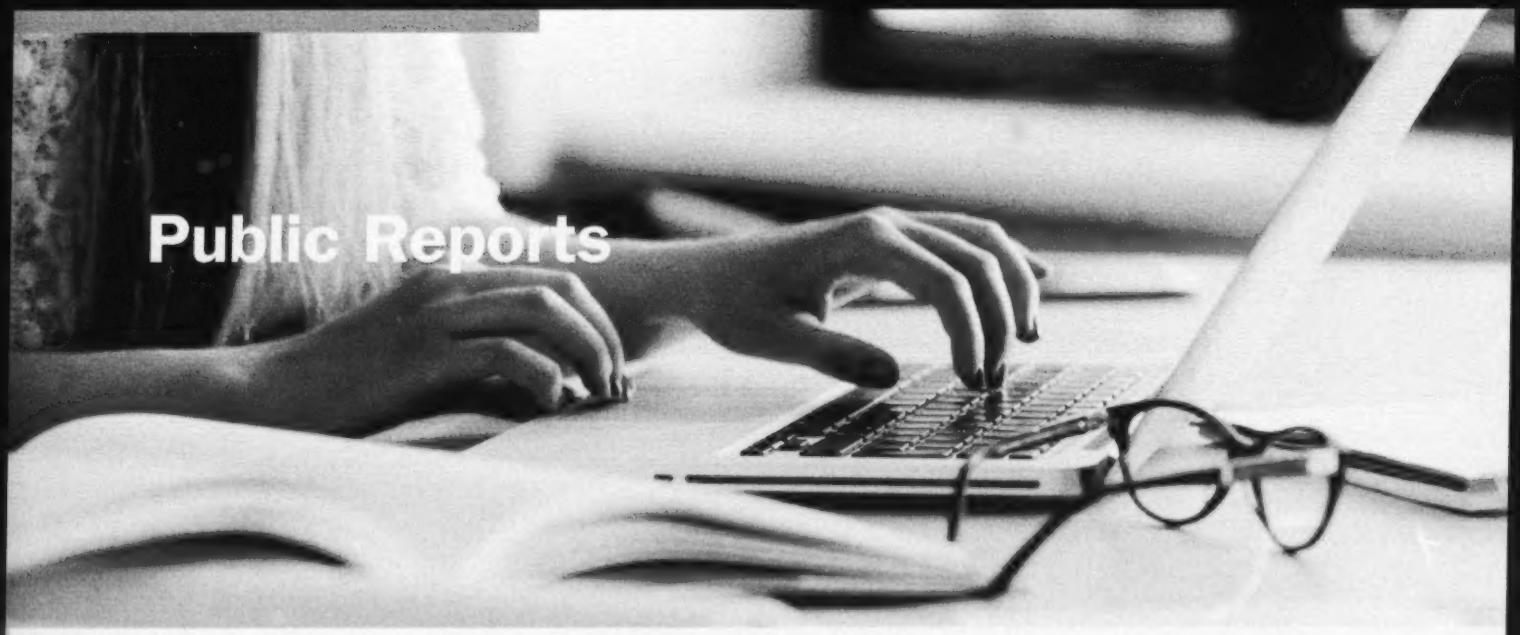
On August 23, 2011, the SHC decided to end the RPO program. Minutes of the committee's decision stated that, on January 1, 2012, letters would be sent to "anyone with previous offers and those who had previously requested information advising them that the program will terminate on March 31, 2012. If they are exercising their option to purchase they must do so before the program termination date." Staff were instructed to keep a list of clients who inquired about the program so they could further advise them at a later date.

After the meeting, SHC officials decided that the notice should only go to "active clients" – a term that different SHC staff seemed to define differently. In the end, this change caused Jerry to not receive notice of the program closure date.

The SHC told us that, despite it not giving him notice, Jerry had already had ample opportunity to purchase his rental unit and that he would not have been approved anyway because he had missed rent payments. Although six consecutive months of steady rent payments was listed as a requirement, the SHC had waived it for others in Jerry's position, so it should have given him the same consideration. We determined that it was unfair not to provide Jerry with information about the RPO program ending. We recommended that:

1. The Saskatchewan Housing Corporation provide Jerry with the opportunity to apply under the Rental Purchase Option program to purchase his rental unit, under the same conditions that were offered to other applicants when the program ended.

   Status: Not Accepted



Public Reports

Update: *Taking Care* Report

On May 13, 2015, the Ombudsman issued a public report, entitled *Taking Care – An Ombudsman Investigation into the Care Provided to Margaret Warholm at the Santa Maria Senior Citizens Home*. The report included 19 recommendations aimed at improving the quality of care being provided by Santa Maria, as well as the oversight and direction being provided by the Regina Qu'Appelle Health Region to all long-term care facilities in the region and the Ministry of Health to all long-term care facilities in the province. The Ombudsman initiated this investigation at the request of the Minister of Health. All recommendations were accepted.

Six months after publishing the report, we requested an update on the progress that each entity had made towards implementing the recommendations. Below is a status report on that progress as of November 2015. Given the public interest in this case, we have asked each entity to make detailed information available to the public, describing the steps they have taken to implement the recommendations.

RECOMMENDATIONS

1. That Santa Maria Senior Citizens Home implement a process to ensure that its staff:
   a. Can identify, manage and treat bedsores.
   b. Understand that they must pay particular attention to advanced or complicated bedsores and know when to consult external resources about treatment.

c. Follow prescribed care plans when caring for bedsores.

d. Are aware of the duty to report bedsores as required by standard 17.1 of the *Program Guidelines for Special-care Homes*.

Status: Implemented

2. That Santa Maria Senior Citizens Home implement a process to ensure residents' charts are up to date and that staff know when and what to chart, in accordance with standards 16.1 and 16.2 of the *Program Guidelines for Special-care Homes*.

Status: Implemented

3. That Santa Maria Senior Citizens Home implement a process to ensure that residents receive adequate hydration and nutrition in accordance with standard 13.5 of the *Program Guidelines for Special-care Homes*.

Status: Implemented

4. That Santa Maria Senior Citizens Home implement a process to ensure that when a resident's weight change exceeds a certain threshold (established in consultation with a dietician) that it be reported to the Director of Care (or equivalent), as well as the resident and family, so that any appropriate interventions can be considered and agreed upon.

Status: Implemented

5. That Santa Maria Senior Citizens Home audit residents' charts and care plans in accordance with its *Quality Assurance* policy (NUR 9.3).

Status: Implemented

6. That Santa Maria Senior Citizens Home implement a process to ensure that care plans are reviewed and updated in accordance with standard 15.5 of the *Program Guidelines for Special-care Homes*.

Status: Implemented

7. That Santa Maria Senior Citizens Home implement a process to ensure effective recognition, assessment and management of residents' pain in accordance with standard 1.4 of the *Program Guidelines for Special-care Homes*.

   Status: Implemented

8. That Santa Maria Senior Citizens Home ensure that its *Transfer Lifting and Repositioning* policy is approved by the Regina Qu'Appelle Health Region and that Santa Maria staff understand the policy, its requirements, and how to conduct a proper lift.

   Status: Implemented

9. That Santa Maria Senior Citizens Home clarify, for both its management and care staff, who has the authority to change or deviate from a resident's care plan.

   Status: Implemented

10. That, in keeping with resident and family centred care, Santa Maria Senior Citizens Home ensures that:
    a. Processes are put in place to fully inform residents and their families of the resident's care needs and of Santa Maria's plans to meet these needs.
    b. These discussions are documented.

    Status: Implemented

11. That the Regina Qu'Appelle Health Region:
    a. Develop and implement policies and procedures to operationalize the standards of care in the *Program Guidelines for Special-care Homes*.
    b. Identify, track and report on specific and measurable outcomes that ensure the standards of care in the *Program Guidelines for Special-care Homes* are met consistently for each long-term care resident.
    c. Include these specific and measurable outcomes as performance requirements in its agreements with long-term care facilities.

    Status: Implementation in progress

12. That the Ministry of Health ensure that all health regions:
    a. Develop and implement policies and procedures to operationalize the standards of care in the *Program Guidelines for Special-care Homes*.
    b. Identify, track and report on specific and measurable outcomes that ensure the standards of care in the *Program Guidelines for Special-care Homes* are met consistently for each long-term care resident.
    c. Include these specific and measurable outcomes as performance requirements in their agreements with long-term care facilities.

    Status: Implementation in progress

13. That the Ministry of Health implement a publicly accessible reporting process that families can use to see whether each long-term care facility is meeting the *Program Guidelines for Special-care Homes*

    Status: Implementation in progress

14. That Santa Maria Senior Citizens Home implement an efficient process for ensuring that all staff caring for a resident are, and remain, aware of concerns and preferences raised by the resident and family members.

    Status: Implemented

15. That Santa Maria Senior Citizens Home take steps to ensure that its *Management of Residents/Family Concerns* policy meets the requirements of standards 17.3 and 2.4 of the *Program Guidelines for Special-care Homes* and is widely available and communicated to staff, residents and their families.

    Status: Implemented

16. That Santa Maria Senior Citizens Home provide a comprehensive process to investigate and protect anyone, including staff, who, in good faith, raise questions or concerns about a resident's care.

    Status: Implemented

17. That the Ministry of Health amend the *Program Guidelines for Special-care Homes* to provide more details of the steps needed in concern-handling and appeal processes, and ensure that the processes are procedurally fair.

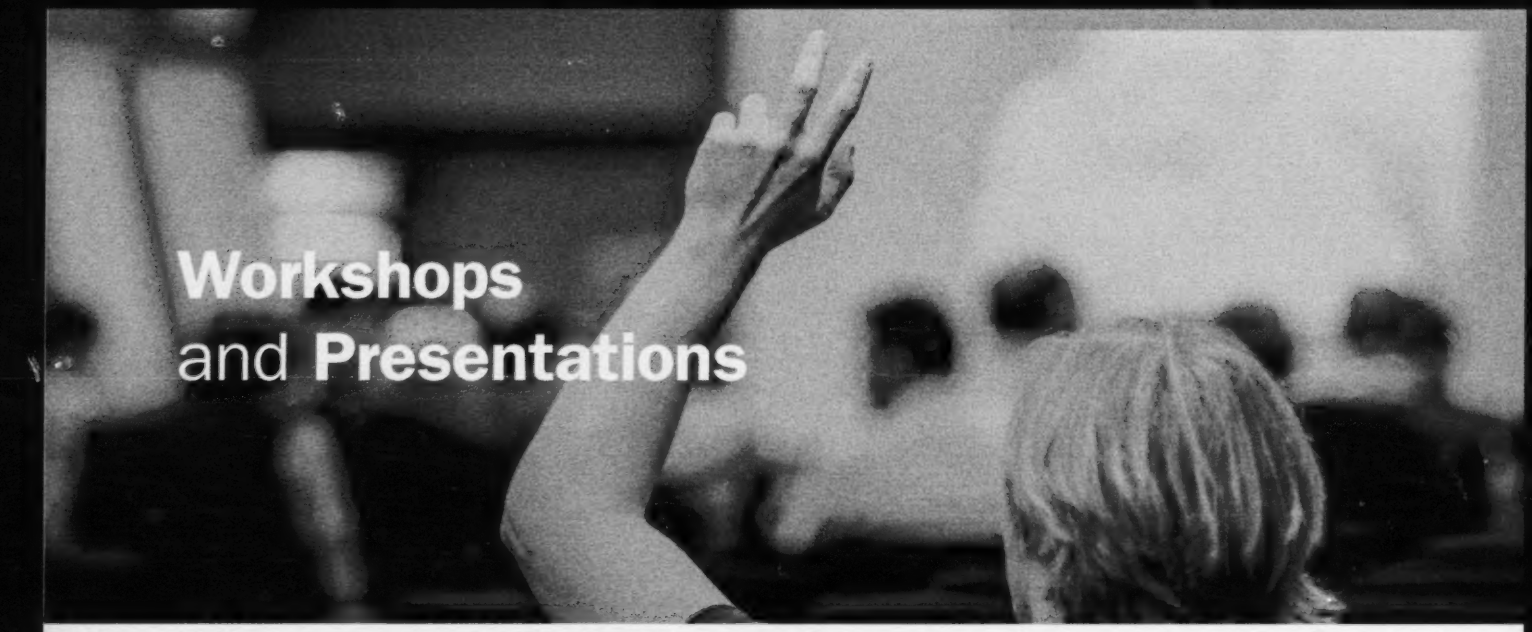
    Status: Implementation in progress

18. That Santa Maria Senior Citizens Home take steps to identify the issues straining its employer-employee relationship and implement an inclusive plan to address these issues.

    Status: Implementation in progress

19. That the Ministry of Health, in consultation with the health regions and other stakeholders:
    a. Identify the care needs of current and future long-term care residents.
    b. Identify the factors affecting the quality of long term care delivery.
    c. Develop and implement a strategy to meet the needs of long-term care residents and to address the factors affecting the quality of long-term care in Saskatchewan; and make the strategy public.

    Status: Implementation in progress



Workshops and Presentations

"I have already started to use the concepts that I have learned and I will use them every day of my life. Anyone who deals with the public should take this course."

– Jan Craig
Consultant,
Customer Experience
SaskPower

Throughout the province, provincial and municipal governments make administrative decisions that affect people's lives. As an Office that is both independent and intended as a last resort, it is important that we educate government and the public about fair decision-making and the role of the Ombudsman. This increases their awareness of our Office, the efforts they can make to resolve issues on their own, and when to contact us.

WORKSHOPS

Our "Fine Art of Fairness" workshops provide government decision-makers an overview of the role of the Ombudsman, and an introduction to making and communicating decisions fairly. These workshops have now been running for 10 years and our Office has trained over 2,600 public servants.

In 2015, we heard positive feedback from government officials about the workshops, as well as concerns that the two-day format was a significant time commitment. With this in mind, we have shortened the course to one day. Our efforts to adjust the workshop to each group have also been appreciated. For example, we try to provide case examples that are aligned with the work of the participants, and in some cases, we can provide more in-depth discussions about specific topics of interest.

Following is a list of the workshops we conducted in 2015.

Open Workshop for all Public Servants, Regina (2)
Open Workshop for Health Sector Employees, Regina
Cognitive Disability Strategy, Saskatoon
Constituency Assistants, Regina
Forum of Canadian Ombudsman/Association of Canadian College and University Ombudspersons Conference, Vancouver
Kelsey Trail Health Region Human Resources / Saskatchewan Government Employees Union, Tisdale
Ministry of Social Services, Saskatoon
Ministry of Social Services, Call Centre, Regina
New Brunswick Ombudsman, Fredericton
North West College, Meadow Lake
Saskatchewan Housing Authority, North Battleford
Saskatchewan Housing Authority, Prince Albert
Saskatchewan Housing Authority, Regina
Saskatchewan Housing Authority, Saskatoon
Saskatchewan Housing Authority, Yorkton
Saskatchewan Property Review Board, Regina
Workers' Compensation Board, Regina
Workers' Compensation Board, Saskatoon

PRESENTATIONS

Presentations and events provide our Office with the opportunity to reach out to the public and to those who serve the public in a variety of roles.

In 2015, we brought back an effective means of outreach to people in communities outside the larger centres of Regina and Saskatoon. We travelled to four communities to present information about the Office and to take complaints in person. These mobile intake days were a success and contributed to a better awareness of our Office in the communities we visited.

Another important audience for our presentations is public servants. At times, we were invited to participate in orientation programs, such as training for new corrections workers.

With the addition of municipal governments to the Ombudsman's jurisdiction in November of 2015, we started providing presentations to various municipal groups to assist them in gaining a basic understanding of our mandate and what to expect if someone makes a complaint to our Office. We have only just begun making contact with municipalities and the people they serve, and will continue to do so in 2016.

Following is a list of the presentations and events we were part of in 2015.

Canadian Patient Relations Conference,
Panel on Complaint Handling
Carpenter High School, Law 30 Class
CLASSIC Law
Courtworker Conference
Hepburn School, Life Transitions Class
Ministry of Justice, Community Corrections
Ministry of Justice – Corrections Worker Orientation
Prince Albert Correctional Centre (2)
Regina Correctional Centre (2)
Saskatoon Correctional Centre (3)
White Spruce Provincial Training Centre (2)
Ministry of Justice, Courtworker Conference
Santa Maria Senior Citizens Home (2)
Saskatchewan Association of Rural Municipalities
Saskatchewan Crop Insurance Corporation, Appeal Panel Orientation
Saskatchewan Government Insurance
Saskatchewan Heritage Foundation
Saskatchewan Legislative Interns
Saskatchewan Polytechnic, Correctional Studies Program
Saskatchewan Seniors Mechanism Spring Conference
Saskatchewan Urban Municipalities Association
Saskatoon Council on Aging
Saskatoon Food Bank and Learning Centre (2)
University of Saskatchewan, Prison Law Class (2)
West Central Municipal Government Committee

Staff from Ombudsman Saskatchewan and Ombudsman Alberta at a joint mobile intake day in Lloydminster.

MOBILE INTAKE

Kindersley / Eatonia
Lloydminster
Meadow Lake
Yorkton

BOOTHS & EVENTS

Saskatoon Council on Aging, Spotlight on Seniors Conference
Saskatchewan Home Economics Teachers' Association/Association of Saskatchewan Home Economists Conference
Saskatchewan Seniors Mechanism Conference
University of Regina, Careers Day (2)
University of Saskatchewan, Sallows Fry Conference
Saskatchewan Student Leadership Conference, Shellbrook

Statistics

Complaint Process

Assess complaint.
Wihin jurisdiction?

NO — Refer appropriately.

YES

Resolution attempted?
Appeal process used?

NO — Refer to appeal process.
Coach on how to resolve.

YES

Review further. Use appropriate services for file issue.
Further action needed?

NO — Explain findings.
Close file.

YES

Make recommendation.
Recommendation accepted?

NO — Discuss with organization.
Consider further action/reports.
Report to complainant. Close file.

YES

Report to complainant.
Close file.

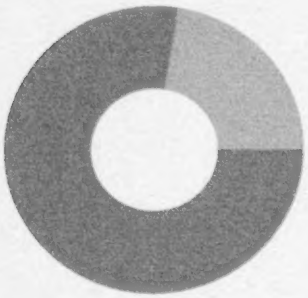
Tracking Files and Progress

RECEIVING FILES

Most complaints we receive fit within our jurisdiction, but a significant minority do not. In those instances, we take the time to redirect the person to the most appropriate office or service.

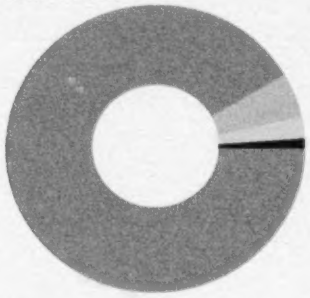
In 2015, we received 3,618 complaints: 2,813 that were within jurisdiction and 805 that were not.

COMPLAINTS RECEIVED



- Within Jurisdiction: 2,813
- Outside Jurisdiction: 805

HOW COMPLAINTS WERE RECEIVED

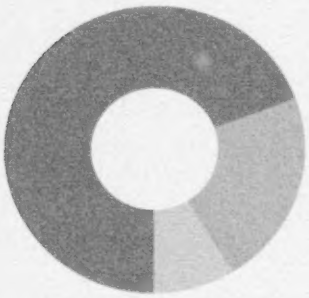


- Phone: 3,310
- Internet Form: 112
- Letter: 75
- Walk-in: 85
- Email: 36

COMPLAINT OUTCOMES

Each complaint is unique and there are many possible outcomes. However, we have grouped outcomes into the four categories defined below. Please note that some complaints contain multiple issues, which may have had different outcomes.

COMPLAINT OUTCOMES



- Initial Support: 1,846
- Resolved: 514
- Recommendations Made: 65
- No Further Action: 234

Outcome Categories

Initial Support	We provided an introductory level of support. For example, we may have made a referral – perhaps to an appeal process, an advocacy service, or an internal complaints process. At this stage, we encourage people to contact us again if their attempts to resolve the matter do not work out.
Resolved	The complaint has been resolved in some manner. For example, an appropriate remedy may have been reached or a better explanation provided for a decision.
Recommendations	We made one or more recommendations related to this complaint.
No Further Action	No further action was required on the file. For example: there may have been no reason to request the government organization to act, there was no appropriate remedy available, or the complainant discontinued contact with our Office.

TIME TO PROCESS CASES

	Target	Actual
Files Closed Within 90 Days	90%	95%
Files Closed Within 180 Days	95%	97%

TIME TO PROCESS CASES

The time it takes to complete and close a case varies, depending on the circumstances and the amount of work required. Many can be closed within a few days, while others may take several months. Overall, our goal is to complete most cases within six months.

COMPLAINTS BY REGION

This map provides an overview of the complaints we received within jurisdiction, separated into five regions, plus Regina and Saskatoon. Complaints received from inmates in correctional centres have been counted separately since they do not represent the home communities of those complainants.

Regions & Larger Cities

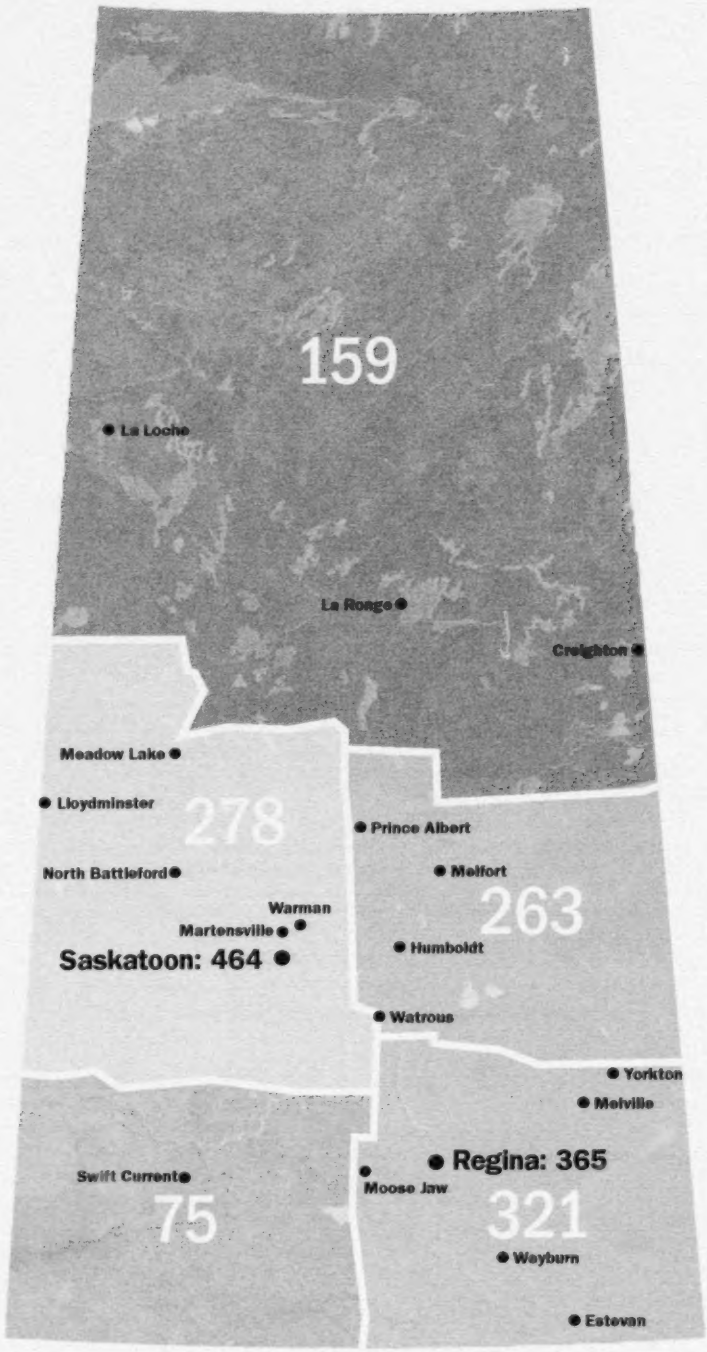
North	159
West Central	278
East Central	263
Southwest	75
Southeast	321
Regina	365
Saskatoon	464

Other Complaints

Correctional Centres	779
Out of Province	55
Address Unknown	54

TOTAL Complaints

TOTAL	2,813



Complaints Received

PUBLIC BODY	COMPLAINTS RECEIVED	
	2015	2014
MINISTRIES		
ADVANCED EDUCATION	**12**	**9**
AGRICULTURE	**6**	**1**
CENTRAL SERVICES	**2**	**2**
ECONOMY	**4**	**14**
EDUCATION	**5**	**5**
ENVIRONMENT	**12**	**4**
FINANCE	**4**	**5**
GOVERNMENT RELATIONS		
Public Safety	1	10
Government Relations – Other	4	1
TOTALS – GOVERNMENT RELATIONS	**5**	**11**
HEALTH		
Drug Plan & Extended Benefits	12	21
Health – Other	23	18
TOTALS – HEALTH	**35**	**39**
HIGHWAYS & INFRASTRUCTURE	**8**	**18**
JUSTICE		
Pine Grove Correctional Centre	53	42
Prince Albert Correctional Centre	110	130
Regina Correctional Centre	351	236
Saskatoon Correctional Centre	256	166
White Birch Remand Centre	7	11
White Spruce Provincial Training Centre	2	n/a
Adult Corrections – Other	14	13
Corrections & Policing – Other	13	3
Court Services	20	13
Maintenance Enforcement Branch	41	34
Public Guardian and Trustee	11	12
Office of Public Registry Administration*	3	1
Office of Residential Tenancies / Provincial Mediation Board	50	47
Justice – Other	19	17
TOTALS – JUSTICE	**950**	**725**

PUBLIC BODY	COMPLAINTS RECEIVED	
	2015	2014
MINISTRIES (CONT'D)		
LABOUR RELATIONS & WORKPLACE SAFETY	**28**	**26**
PARKS, CULTURE & SPORT	**3**	**1**
SOCIAL SERVICES		
Child & Family Services	117	83
Housing	62	70
Income Assistance & Disability Services Division – Community Living Service Delivery	9	5
Income Assistance & Disability Services Division – Saskatchewan Assured Income for Disability	126	126
Income Assistance & Disability Services Division – Saskatchewan Assistance Program	410	383
Income Assistance & Disability Services Division – Transitional Employment Allowance	54	39
Income Assistance & Disability Services Division – Income Supplement Programs – Other	26	18
Social Services – Other	10	7
TOTALS – SOCIAL SERVICES	**814**	**731**

BOARDS		
FARMLAND SECURITY BOARD	**1**	**1**
HIGHWAY TRAFFIC BOARD	**9**	**3**
LABOUR RELATIONS BOARD	**1**	**2**
LANDS APPEAL BOARD	**0**	**2**
SASKATCHEWAN MUNICIPAL BOARD	**1**	**0**
SASKATCHEWAN PENSION PLAN BOARD OF TRUSTEES	**0**	**1**
SASKATCHEWAN SOCIAL SERVICES APPEAL BOARD	**8**	**6**
SOCIAL SERVICES REGIONAL APPEAL COMMITTEES	**1**	**2**
SURFACE RIGHTS ARBITRATION BOARD	**1**	**0**
WORKERS' COMPENSATION BOARD	**126**	**98**

*The Information Services Corporation is no longer a Crown corporation, but still provides public registry services under contract with the province. Complaints about these services will now be reported under the Office of Public Registry Administration, Ministry of Justice.

PUBLIC BODY	COMPLAINTS RECEIVED	
	2015	2014
REGIONAL HEALTH AUTHORITIES & ENTITIES		
REGIONAL HEALTH AUTHORITIES		
ATHABASCA REGIONAL HEALTH AUTHORITY	0	0
CYPRESS REGIONAL HEALTH AUTHORITY	3	2
FIVE HILLS REGIONAL HEALTH AUTHORITY	13	9
HEARTLAND REGIONAL HEALTH AUTHORITY	3	1
KEEWATIN REGIONAL HEALTH AUTHORITY	0	1
KELSEY TRAIL REGIONAL HEALTH AUTHORITY	4	2
MAMAWETAN CHURCHILL RIVER REGIONAL HEALTH AUTHORITY	2	2
PRAIRIE NORTH REGIONAL HEALTH AUTHORITY	8	6
PRINCE ALBERT PARKLAND REGIONAL HEALTH AUTHORITY	3	11
REGINA QU'APPELLE REGIONAL HEALTH AUTHORITY	23	25
SASKATOON REGIONAL HEALTH AUTHORITY	42	25
SUN COUNTRY REGIONAL HEALTH AUTHORITY	5	3
SUNRISE REGIONAL HEALTH AUTHORITY	11	13
TOTALS – REGIONAL HEALTH AUTHORITIES	117	100

*HEALTH ENTITIES...		
... IN THE CYPRESS HEALTH REGION	2	0
... IN THE FIVE HILLS HEALTH REGION	5	2
... IN THE HEARTLAND HEALTH REGION	7	1
... IN THE PRAIRIE NORTH HEALTH REGION	2	1
... IN THE PRINCE ALBERT PARKLAND HEALTH REGION	4	1
... IN THE REGINA QU'APPELLE HEALTH REGION	42	10
... IN THE SASKATOON HEALTH REGION	35	18
... IN THE SUN COUNTRY HEALTH REGION	2	2
... IN THE SUNRISE HEALTH REGION	10	5
TOTALS – HEALTH ENTITIES BY REGION	109	40

*These entities are grouped and listed based on the health region in which they are located, not on their governance structure.

PUBLIC BODY	COMPLAINTS RECEIVED	
	2015	2014
CROWN CORPORATIONS		
FINANCIAL & CONSUMER AFFAIRS AUTHORITY	9	3
PHYSICIAN RECRUITMENT AGENCY OF SASKATCHEWAN	1	0
SASKATCHEWAN CROP INSURANCE CORPORATION	6	10
SASKATCHEWAN GOVERNMENT INSURANCE (SGI)		
Auto Fund	43	35
Claims Division – Auto Claims	89	80
Claims Division – No Fault Insurance	46	38
Claims Division – Other / SGI Canada	34	29
SGI – Other	17	8
TOTALS – SGI	229	190
SASKATCHEWAN LIQUOR & GAMING AUTHORITY	1	1
SASKATCHEWAN TRANSPORTATION COMPANY (STC)	3	2
SASKENERGY	32	42
SASKPOWER	81	84
SASKTEL	43	51
SASKWATER	0	1
WATER SECURITY AGENCY	13	15
eHEALTH	14	8

PUBLIC BODY	COMPLAINTS RECEIVED	
	2015	2014
MUNICIPALITIES		
MUNICIPALITIES UNDER *THE CITIES ACT*	6	n/a
MUNICIPALITIES UNDER *THE MUNICIPALITIES ACT*	25	n/a
MUNICIPALITIES UNDER *THE NORTHERN MUNICIPALITIES ACT, 2010*	2	n/a
COMMISSIONS		
APPRENTICESHIP & TRADES CERTIFICATION COMMISSION	0	4
AUTOMOBILE INJURY APPEAL COMMISSION	1	3
PUBLIC SERVICE COMMISSION	1	1
SASKATCHEWAN HUMAN RIGHTS COMMISSION	19	14
SASKATCHEWAN LEGAL AID COMMISSION	42	25
SASKATCHEWAN PUBLIC COMPLAINTS COMMISSION	11	3
TEACHERS' SUPERANNUATION COMMISSION	1	1
AGENCIES & OTHER ORGANIZATIONS		
CONEXUS ARTS CENTRE	0	1
EMPLOYMENT ACT ADJUDICATORS	2	0
SASKATCHEWAN ASSESSMENT MANAGEMENT AGENCY (SAMA)	1	1
SASKATCHEWAN CANCER AGENCY	1	0
SASKATCHEWAN POLYTECHNIC	6	6
TECHNICAL SAFETY AUTHORITY OF SASKATCHEWAN (TSASK)	1	0
TOTAL COMPLAINTS RECEIVED WITHIN JURISDICTION	**2,813**	**2,312**

Complaints Received Outside Jurisdiction

TOPIC	COMPLAINTS RECEIVED
CONSUMER (INCLUDING LANDLORD/TENANT)	257
COURTS/LEGAL	36
EDUCATION	10
FEDERAL GOVERNMENT	122
FIRST NATIONS GOVERNMENT	9
LOCAL GOVERNMENT*	80
HEALTH INSTITUTIONS OUTSIDE OUR JURISDICTION	37
POLICE COMPLAINTS	80
PRIVATE MATTER	28
PROFESSIONAL	58
OTHER	88
TOTALS	805

*Local government complaints did not fall under our jurisdiction until November 19, 2015.

Budget

	2013–2014 AUDITED FINANCIAL STATEMENT*	2014–2015 AUDITED FINANCIAL STATEMENT*	2015–2016 BUDGET**
REVENUE			
General Revenue Fund appropriation	$3,512,849	$3,209,314	$3,429,000
Miscellaneous	$28	($2)	–
TOTAL REVENUE	$3,512,877	$3,209,312	$3,429,000
EXPENSES			
Salaries & benefits	$2,418,772	$2,514,749	$2,571,000
Office space & equipment rental	$301,375	$312,826	$313,700
Communication	$35,800	$54,142	$65,000
Miscellaneous services	$78,364	$79,281	$94,200
Office supplies & expenses	$29,266	$29,500	$28,800
Advertising, promotion & events	$133,436	$54,171	$82,600
Travel	$102,828	$63,268	$69,700
Amortization	$154,912	$143,037	–
Dues & fees	$78,914	$82,374	$129,000
Repairs & maintenance	$61,685	$16,532	$75,000
Capital asset acquisitions	–	–	–
Loss on disposal of capital assets	–	$2,762	–
TOTAL EXPENSES	$3,395,352	$3,352,642	$3,429,000
ANNUAL (DEFICIT) SURPLUS	$117,525	($143,330)	–

*These columns are based on our audited financial statements, which follow our fiscal year (April – March) and our annual report follows the calendar year. The audited financial statements are available on our website at www.ombudsman.sk.ca.

**Due to the timing of this report, 2015–16 numbers reflect the budgeted amount rather than the actual.

Staff

Regina Office

Rahil Ahmad, Assistant Ombudsman

Jaime Carlson, Assistant Ombudsman

Kelly Chessie, Assistant Ombudsman

Sherry Davis, Assistant Ombudsman

Leila Dueck, Director of Communications

Jennifer Hall, Assistant Ombudsman

Arlene Harris, Assistant Ombudsman

Pat Lyon, Assistant Ombudsman (term)

Janet Mirwaldt, Deputy Ombudsman

Shyla Prettyshield, Administrative Assistant (term)

Carol Spencer, Complaints Analyst

Gregory Sykes, General Counsel

Harry Walker, Complaints Analyst (term)

Beverley Yuen, Executive Administrative Assistant

Saskatoon Office

Christy Bell, Assistant Ombudsman

Jeff Cain, Assistant Ombudsman

Renée Gavigan, Deputy Ombudsman

Adrienne Jacques, Assistant Ombudsman (term)

Ryan Kennedy, Administrative Assistant (part-time)

Sherry Pelletier, Assistant Ombudsman

Shelley Rissling, Administrative Assistant (term)

Andrea Smandych, Manager of Administration

Diane Totland, Complaints Analyst

Kathy Upton, Complaints Analyst

Rob Walton, Assistant Ombudsman